ESRD DEATH NOTIFICATION END STAGE RENAL DISEASE MEDICAL INFORMATION SYSTEM

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0448. The time required to complete this information collection is estimated to average 17 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, Mailstop N321426, 7500 Security Boulsayard, Politicard Management and Budget Westigned and Control National Control Nation

the data needed, and complete and review the information coll: N2-14-26, 7500 Security Boulevard, Baltimore, Maryland 212 1. PATIENT'S LAST NAME	ection. If you have any comments concerning 444-1850 and to the Office of the Information FIRST		(s) or suggestions for improving this form, please write to: HCFA, Mailst Management and Budget, Washington, D.C. 20503. HEALTH INSURANCE CLAIM NUMBER			
O DATIFACTION OF Y	-NTIO OTATE OF DEGIDENC	DE 5 DATE OF	DATE OF DEATH			
3. PATIENT'S SEX a. Male b. Female	ENT'S STATE OF RESIDENC		F BIRTH DAY YEAR 6. DATE OF DEATH MONTH DAY YEAR			
7. PROVIDER NAME AND ADDRESS (CITY AND STATE)		<u> </u>			
O DEOVIDED NUMBER			40 WAS AN AUTOROV PERFORMED			
8. PROVIDER NUMBER	9. PLACE OF DEATH (Che a. Hospital b. Dialysis		Other 10. WAS AN AUTOPSY PERFORMED Yes b. No			
11. CAUSES OF DEATH (Enter code for	· · · · · · · · · · · · · · · · · · ·					
a. Primary Cause	b. Were there Secondary Cause	□ No es? □ Yes, Specify	(1) (3) (4)			
a. I filliary Gause			(4)			
	<u>LIST OF</u>	CAUSES				
CARDIAC 23 Myocardial infarction, acute 24 Hyperkalemia 25 Pericarditis, incl. cardiac tamponade 26 Atherosclerotic heart disease 27 Cardiomyopathy 28 Cardiac arrhythmia 29 Cardiac arrest, cause unknown 30 Valvular heart disease 31 Pulmonary edema due to exogenous fluid VASCULAR 35 Pulmonary embolus 36 Cerebrovascular accident including intracranial hemorrhage 37 Ischemic brain damage/Anoxic encephalopathy 38 Hemorrhage from transplant site 39 Hemorrhage from vascular access 40 Hemorrhage from dialysis circuit 41 Hemorrhage from surgery (not 38, 39 or 4 43 Other hemorrhage (not Codes 38-42, 72) 44 Mesenteric infarction/ischemic bowel	INFECTION 49 Septicemia, due to 50 Septicemia, due to 51 Septicemia, due to 51 Septicemia, due to 52 Septicemia, other 53 Pulmonary infection 54 Pulmonary infection 55 Pulmonary infection 56 Viral Infection, CMV 57 Viral Infection, Othe 58 Tuberculosis 59 A.I.D.S. 60 Infections, other LIVER DISEASE 64 Hepatitis B 65 Other viral hepatitis 66 Liver-drug toxicity 67 Cirrhosis 68 Polycystic liver dise 1) 69 Liver failure, cause	peritonitis peripheral vascular n (bacterial) n (fungal) n (other) V er (not 64 or 65)	GASTRO-INTESTINAL (see also 50) 72 Gastro-intestinal hemorrhage 73 Pancreatitis 74 Fungal peritonitis 75 Perforation of peptic ulcer 76 Perforation of bowel (not 75) OTHER 80 Bone marrow depression 81 Cachexia 82 Malignant disease, patient ever on immunosuppressive therapy 83 Malignant disease (not 82) 84 Dementia, incl. dialysis dementia, Alzheimer's 85 Seizures 86 Diabetic coma, hyperglycemia, hypoglycemia 87 Chronic obstructive lung disease (COPD) 88 Complications of surgery 89 Air embolism 90 Accident related to treatment 91 Accident unrelated to treatment 92 Suicide 93 Drug overdose (street drugs) 94 Drug overdose (not 92 or 93) 98 Other identified cause of death, please specif			
12. FOR ALL DEATHS INDICATE YE	-S/NO	13 IE DEC!	99 Unknown EASED RECEIVED A TRANSPLANT			
Renal replacement therapy discontinued placement therapy discontinued placement therapy discontinued placement the following:		No	of most recent transplant			
a. Following HD and/or PD access fa	ilure d. Following acute r	medical b. Was k	MONTH DAY YEAR sidney functioning (patient not on dialysis) at time			
b. Following transplant failure	complication	of dea				
c. Following chronic failure to thrive	e. U Other		c. Did transplant patient resume chronic maintenance dialysis prior to death? ☐ Yes ☐ No			
14. REMARKS						
15. NAME OF PHYSICIAN	16. SI	GNATURE OF PERSO	ON COMPLETING THIS FORM DATE			
This report is required by law (42, U.S.C.	426; 20 CFR 405, Section 21	33). Individually identif	fable patient information will not be disclosed			

except as provided for in the Privacy Act of 1974 (5 U.S.C. 5520; 45 CFR Part 5a).

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PATIENT'S LAST NAME	FIRST	 		HEALTH INSURA				
3. PATIENT'S SEX 4. PATIE	NT'S STATE OF RESI	IDENCE 5	5. DATE OF E	BIRTH 6	B. DATE OF DE	ATH		
a. Male b. Female		MONTH DA	AY YEAR	MONTH DAY	YEAR			
7. PROVIDER NAME AND ADDRESS (CITY AND STATE)							
8. PROVIDER NUMBER	9. PLACE OF DEATH	H (Check one)		10. WAS	AN AUTOPSY PE	RFORMED?		
	a. Hospital b. D	oialysis c. DH	lome d. O	ther a.	Yes b	No		
11. CAUSES OF DEATH (Enter code for				(1)	(3)			
a. Primary Cause	b. Were there Secondary		No Yes, Specify	(2)	(4)			
	<u>LIS</u> 1	OF CAUSE	<u>:S</u>					
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	- 0			99 Unknown				
12. FOR ALL DEATHS INDICATE YE Renal replacement therapy discontinued p If Yes, check one of the following:				ASED RECEIVE most recent trans				
a. Following HD and/or PD access fail		acute medical		ney functioning (p	atient not on dial	ysis) at time		
b. Following transplant failure	complication	on	of death		∕es □ No □ U			
e. U Other c. Following chronic failure to thrive			 c. Did transplant patient resume chronic maintenance dialysis prior to death? ☐ Yes ☐ No 					
14. REMARKS			-					
15. NAME OF PHYSICIAN		16. SIGNATURE	E OF PERSON	N COMPLETING 1	THIS FORM	DATE		

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3. PATIENT'S SEX a. Male b. Female 7. PROVIDER NAME AND ADDRESS (ENT'S STATE OF RESIDE	ENCE 5. DATE MONT	E OF BIRTH TH DAY YEAR	6. DATE OF DEATH MONTH DAY YEAR
		Check one) lysis c. Home d	_	S AN AUTOPSY PERFORMED? Yes b. No
11. CAUSES OF DEATH (Enter code for a. Primary Cause	m List of Causes below.) b. Were there Secondary Ca	□ No auses? □ Yes, Spe	(1) ecify (2)	(3)
	LIST C	OF CAUSES		
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 a. Following HD and/or PD access fail b. Following transplant failure c. Following chronic failure to thrive 14. REMARKS 	lure d. Following acucomplication e. Other	c. D	of death?	(patient not on dialysis) at time Yes □ No □ Unknown sume chronic maintenance □ Yes □ No
15. NAME OF PHYSICIAN	16.	. SIGNATURE OF PE	ERSON COMPLETING	THIS FORM DATE

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